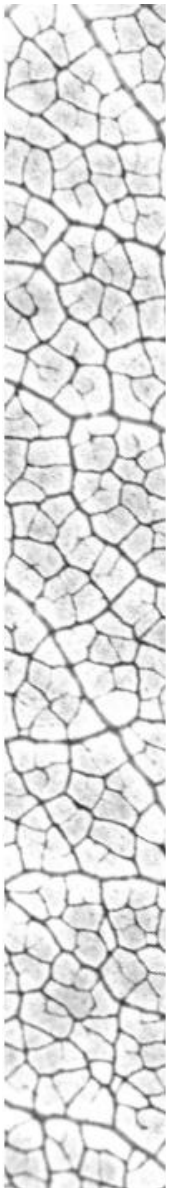

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The influence of family psychoeducation to self-awareness family in caring for family members who have mental disorders

Hanik Endang Nihayati [1*], Elma Safira Istizabana [1], Aria Aulia Nastiti [1]

[1] Faculty of Nursing, Universitas Airlangga, Surabaya, INDONESIA
*Corresponding author: hanik-e-n@fkp.unair.ac.id

Abstract
Psychiatric or mental disorder is also called the deviation from the ideal state of mental health. The fact, there is still many families who are neglect family members with a mental disorder. This occurs because the family feels embarrassed, stressed, and burdened. Treatment and care are always undoubtedly able to have an impact on family life, for example, the issues of the economy, psychology, and social family. One of the interventions to reduce the psychological burden is the giving of family psychotherapy education. The purpose of this study was to identify the influence of family psychoeducation to self-awareness family in caring for family members who have mental disorders. This study used a quasi-experimental pre- post-test control group design by using purposive sampling that obtained 20 patients treatment groups, and 20 patients control groups. Data were collected by a questionnaire. Data were analyzed by Wilcoxon Signed Rank Tests and Mann-Whitney Tests. Wilcoxon Tests results showed p = 0,000 (p≤0,05), meaning that family psychoeducation affects the increased self-awareness of family in caring for family members who have experienced psychiatric. The Mann-Whitney Test results showed p = 0,000 (p≤0.05), meaning there was a significant difference in granting psychoeducation against the treatment and control group. It can be concluded that a good self-awareness family will affect the improvement of the quality of caring to the client and decrease the number of recurrences of the client.

Keywords: family psychoeducation, mental disorder, self-awareness family

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INTRODUCTION

The family, as the smallest unit of society, has a very important role in the prevention, early recognition, and treatment of mental disorders clients, including providing emotional support and motivation to take therapy (Sari et al., 2019). At this time, there are still many families who neglect family members with mental disorders. This happens because the family is embarrassed, stressed, and feels burdened to have family members who have mental disorders (Saragih et al., 2019). Treatment and care for family members with mental disorders are also not only brief but require time long and routine. Continual treatment and care can certainly have an impact on family life, such as family economic, psychological, and social problems. One of intervention that given to reduce the psychological burden is the provision of psychoeducation to the family (Erfina et al., 2019; Mikhaylovsky et al., 2019). Until now, in Mojo Subdistrict, family psychoeducation about mental disorders towards self-awareness still needs to be studied.

According to WHO, in 2016, there were about 35 million people affected by depression, 60 million people affected by bipolar disorder, 21 million people affected by schizophrenia, and 47.5 million affected by dementia (WHO, 2016). The number of people with mental disorders in Indonesia based on the results of the Ministry of Health Basic Health Research (Riskesdas) in 2013 was 236 million people with the category of mild mental illness 6% of the population, 0.17% suffering from severe mental disorders, and 14.3% of them were put in a tack. Recorded as many as 6% of people aged 15-24 years experience mental disorders (Kemenkes RI, 2013).

According to data from the East Java Social Service in 2016, people with mental disorders in East Java reached 2,369 people. That number increased by 750 people compared to 2015, which was only 1,619 people. A total of 719 people with mental disorders are still put

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in their families, and 939 sufferers are free and not treated at the Mental Hospital (Suswinarto et al., 2015).

Data obtained from the Mojo Public Health Center states that the number of people with mental disorders in Mojo Sub-district continues to increase. In 2014 there were 126 people with mental disorders in Mojo Subdistrict, then in 2015, there were 162 people and now reached 180 people. Data of people with mental disorders in Mojo Subdistrict in 2017 covering 12 villages stated that the number of people with mental disorders in Jugo Village was 27 people, Sukoanyar Village 21 people, Kraton Village 19 people, Blimbing Village 4 people, Petok Village 12 people, Mlati Village 13 people, Mojo Village 8 people, Ploso Village 13 people, Mondo Village 14 people, Tambibendo Village 19 people, Keniten Village 19 people, Surat Village 11 people. Mental disorder client data posted from 2013 to 2017 has decreased, namely in 2013 as many as 12 people, in 2014 there were five people, in 2015 there were one people, in 2016 there were one people, and in 2017 there were one people. Re-entry occurred in 2016 totaling four people, and in 2017 there were six people. Data of people with mental disorders who seek treatment at the Mojo Health Center in 2017 has decreased every month, namely in January as many as 60 people, 59 people in February, March as many as 51 people, and April as many as 50 people.

The results of interviews conducted by researchers on April 3, 2017, against mental nurses at the Mojo Public Health Center stated that almost all families with mental disorders clients are still afraid and unable to care more intensively at home. Families only treat basic needs, such as eating, drinking, and bathing. The perceived burden families living with families with mental disorders is caused by economic and social factors. In addition, the burden borne by the family takes the form of subjective and objective burdens. The burden becomes a stressful lifetime experience, thus making coping ineffective (Yusuf et al., 2012). Lack of family motivation to take proper care of client with mental disorder makes the family burden more complex (Nihayati et al., 2016).

According to Lawrence Green's theory, there are three factors that influence changes in the behavior of a person or group, namely predisposing factors, enabling factors, and reinforcing factors. Precipitating factors include knowledge, attitudes, and behavior. Knowledge is a very important domain for the formation of one's actions. Before someone takes action, the individual experiences a process of adopting behavior that includes *awareness, interest, evaluation, trial,* and *adoption*. These factors affect the role of the family in caring for family members who experience mental disorders (Notoatmodjo, 2007).

The family has an important role in mental health efforts, so knowledge about mental health needs to be provided through health education and psychoeducation. Also, information about care at home, and psychological support to family members need to be done. Psychoeducation therapy provided to the client's family aims to increase family awareness, improve family attitudes and knowledge related to illness. It is hoped that this intervention can ease family burdens and stress in caring for family members with mental disorders (Putri and Effendy, 2019; Zhuang and Qiao, 2018).

Family psychoeducation is a therapy that is used to provide information to families to improve their abilities in caring for their family members with mental disorders, so that families are expected to have positive coping with stress and the burden they experience. Family psychoeducation can increase family self-awareness, thereby accelerating client recovery and minimizing client recurrence rates. Conversely, a lack of family psychoeducation will adversely affect the client, such as a recurrence rate that rises because there is no support or motivation from the family to undergo treatment (Wiyati et al., 2010).

Another study by Rosmaharani in 2015 showed that there was a decrease in anxiety levels and decreased perceptions of family burden in groups that were given family psychoeducation treatment (Rosmaharani, 2015). Based on data obtained by researchers and from several previous studies, researchers were interested in examining the effect of family psychoeducation on family self-awareness in caring for family members who experience mental disorders.

METHODS

The design of study was Quasi-experimental with a pre-post-test and control group design. This research conducted the pre-test before treatment and post-test after treatment. The sample in this study was 40 respondents, that divided into two groups, control and treatment group, each group had 20 respondents. The treatment group was the group that receives treatment in the form of family psychoeducation and the control group that did not receive treatment. This research conducted in one of the work areas of the Public Health Center in the Kediri Regency area.

The instruments in this study were the Family Psychoeducation Module and a questionnaire to measure the variables of family self-awareness. The questionnaire consisted of questions that were used to obtain information from respondents. The questionnaire in this study consisted of the Demographic Questionnaire and the Family Self-Awareness Questionnaire.

The analysis data that employed in this study was the Wilcoxon Signed Rank Test statistic test with a significance level of $p \leq 0.05$. The aim of the test to compare the value of the dependent variable before and after treatment. Then to find out the influence of

Table 1. The characteristics of family who lived with family member with mental disorder in treatment and control group

Family Characteristics		Treatment		Control		Total	
		n	%	n	%	n	%
Age:							
	Late teens	2	10.0	2	10.0	4	10.0
	Early adulthood	4	20.0	10	50.0	14	35.0
	Late adulthood	6	30.0	0	0.0	6	15.0
	Early Elderly	3	15.0	4	20.0	7	17.5
	Late Elderly	4	20.0	2	10.0	6	15.0
	Old man	1	5,0	2	10.0	3	7.5
Gender:							
	Male	4	20.0	10	50.0	14	35.0
	Female	16	80.0	10	50.0	26	65.0
Education:							
	Elementary (SD)	12	60.0	11	55.0	23	57.5
	Junior High (SMP)	4	20.0	6	30.0	10	25.0
	Senior High (SMA)	4	20.0	3	15.0	7	17.5
Profession:							
	Farmers	7	35.0	6	30.0	13	32.5
	Housewife	5	25.0	5	25.0	10	25.0
	Labor	1	5,0	5	25.0	6	15.0
	Private	7	35.0	4	20.0	11	27.5
Income:							
	> Rp 2,000,000	0	0.0	0	0.0	0	0.0
	IDR 1,000,000 up to IDR 2,000,000	1	5,0	3	15.0	4	10.0
	<Rp 1,000,000	19	95.0	17	85.0	36	90.0
Relationship with clients:							
	Biological father	3	15.0	4	20.0	7	17.5
	Biological mother	7	35.0	5	25.0	12	30.0
	Younger sibling	5	25.0	6	30.0	11	27.5
	Older sibling	4	20.0	4	20.0	8	20.0
	Husband	0	0.0	1	5,0	1	2.5
	Biological children	1	5,0	0	0.0	1	2.5

independent variables on the dependent variable was done using the Mann-Whitney Test statistic test with a significance level of $p \leq 0.05$.

RESULTS

In **Table 1**, from the 20 respondents, the age group of the most treatment group was a late adult (36-45 years) by 30% while the age of the control group was mostly early adult (26-35) by 50%. The sex of the treatment group is 80% female, and the rest are male, while the control group has the same number of respondents male and female gender. The level of education in the treatment group and the majority control group was 60% and 55% primary. In the treatment and control groups, there were similarities in the work of the respondents, is the majority worked as farmers with a percentage of 35% and 15.8%, respectively. The level of income in the treatment and control groups is similar, with the majority earning under one million rupiah with a percentage of 95% and 85%, respectively. The family relationship with the client in the treatment group was dominated by the biological mother relationship by 35%, while the control group was dominated by the sibling relationship by 30%.

Table 2 shows that the majority of mental disorder clients in the treatment and control groups were aged in the early adult category (26-35 years), namely 50% and 80%. The majority in the treatment group and the control group were males, namely 55% and 60%. Routine treatment of mental disorders clients treatment group and the control group is not routine treatment with a percentage of 100% each. Nursing diagnosis of mental disorders client treatment and control groups dominated by violent behavior with a percentage of 25% and 30%, respectively. The duration of the client suffered a mental disorder in the treatment group was in the old category (> 10 years) at 50% and in the control group was in the long enough category (6-10 years) at 45%.

Table 3 identifies the scale of self-awareness before being given a psychoeducation intervention. The test results using the Wilcoxon Test treatment group that is $p = 0,000 < 0.05$. This means that the psychoeducation provided has a significant effect on family self-awareness that is able to increase family self-awareness in caring for family members who have mental disorders. In the control group, the value of $p = 0.254 > 0.05$, this means there is no change. Mann Whitney Test results obtained Asymp values. Sig. 0,000 <0.05, then according to the basis of decision making in the Mann Whitney Test, it can be concluded that Ho was rejected. Rejection of Ho means that there are significant differences in the provision of psychoeducation to the treatment and control groups.

DISCUSSION

The results showed that the majority in the treatment group had good self-awareness, but there were three respondents whose self-awareness did not change after given a psychoeducation intervention. Judging from the characteristics of family demographics, these three respondents are over 50 years old, and their last education in elementary school. This is related to the

Table 2. The characteristic of mental disorder client in treatment and control groups

Family Characteristics	Treatment		Control		Total	
	n	%	n	%	n	%
Age:						
Late teens	5	25.0	4	20.0	9	22.5
Early adulthood	10	50.0	16	80.0	26	65.0
Late adulthood	4	20.0	0	0.0	4	10.0
Early Elderly	1	5,0	0	0.0	1	2.5
Late Elderly	0	0.0	0	0.0	0	0.0
Old man	0	0.0	0	0.0	0	0.0
Gender:						
Male	11	55.0	12	60.0	23	57.5
Female	9	45.0	8	40.0	17	42.5
Treatment Routine:						
Often	0	0.0	0	0.0	0	0.0
Rarely	20	100.0	20	100.0	40	100.0
Nursing diagnoses:						
Social isolation	3	15.0	4	20.0	7	17.5
Violent behavior	5	25.0	6	30.0	11	27.5
Self-care deficit	2	10.0	2	10.0	4	10.0
Hallucinations	3	15.0	2	10.0	5	12.5
Delusion	1	5,0	3	15.0	4	10.0
Risk of suicide	3	15.0	2	10.0	5	12.5
Low self-esteem	3	15.0	1	5,0	4	10.0
Illness period:						
New	5	25.0	4	20.0	9	22.5
Long enough	5	25.0	9	45.0	14	35.0
Long	10	50.0	7	35.0	17	42.5

Table 3. Distribution of family self-awareness values, Wilcoxon test, and Mann-Whitney test of treatment group and control group

		Treatment group				Control group			
		Pre Test		*Post Test*		*Pre Test*		*Post Test*	
		n	%	n	%	n	%	n	%
Self-Awareness	Good	12	60.0	18	90.0	8	40.0	8	40.0
	Bad	8	40.0	2	10.0	12	60.0	12	60.0
Wilcoxon Signed-Rank Tests		p = 0,000				p = 0.254			
Positive Ranks		17				3			
Negative Ranks		0				6			
Ties		3				11			
Mann-Whitney Tests		p = 0,000							

genetic clock theory, where a cell will die if it reaches its time. Decreased cognitive function occurs along with increasing age and also due to associated risk factors. These risk factors include: 1) Stress, 2) Genetic/family history, 3) Neurodegenerative diseases, 4) Lifestyle, 5) Environment and 6) Age (Issaacs, 2005; Martono and Pranarka, 2009).

According to the Indonesian Ministry of Health, more rural residents have low education because of a lack of education facilities. This is proved by the high percentage of those working in agriculture (Kemenkes RI, 2013). A low level of education means less mental and environmental experiences, which have an impact on the lack of intellectual stimulation. Higher education improves cognitive skills needed to be able to continue learning outside of school (Laflamme et al., 2004). Research conducted by Redman in 1993 which states that higher education will provide greater knowledge resulting in the habit of maintaining better health. When individuals become aware of their health, they tend to seek help as soon as possible to overcome the problem at hand (Potter et al., 2016). Several studies have identified the importance of education as a source of coping and prevention of mental disorders. Education is more meaningful than income levels in determining the use of mental health facilities. Individuals with higher education use mental health facilities more often than respondents with low education (Stuart, 2014).

Based on this study, the researchers concluded that three respondents had the same self-awareness level before and after the intervention. This is caused by characteristics of the age of respondents over 50 years. At that age, the cognitive abilities of the respondents declined, and the education of the respondents was a primary school. Low education causes individuals to be less in searching and getting information. The low behavior of seeking and obtaining information causes a tendency for respondents to choose the same answer with the pre-test answers.

The results in the control group showed there were positive ranks of three respondents and the ties of eleven respondents. Judging from the characteristics of family demographics, 14 respondents are elementary school graduates, work as farmers/farm laborers, and earn less than one million rupiahs each month. Knowledge is influenced by educational factors. Knowledge is very closely related to education, where it is expected that with higher education, the person will be more knowledgeable. Higher education will provide greater knowledge so as to result in the habit of

maintaining better health. Ross and Mirowsky in their research concluded, the positive effect of the length of (years) education with consistent health, with the argument that the length of the school year can develop an effective life capacity that will ultimately affect health, including working full-time, can carry out work with good, improve welfare, the economy, can control themselves, be more able to support social, and healthy lifestyle (Pradono and Sulistyowati, 2014).

According to Azwar, in 2013, work is an effort that must be done by every human being for the purpose of sustaining life, a work environment filled with the complexity of its employees can affect the experience and ultimately can affect one's knowledge (Azwar, 2007). The work of respondents, the majority of whom work as farmers, enables respondents to get less correct information about what has never been known.

Family members who have high incomes will support the health status of other family members who experience illness because it can provide all the needs of both primary and secondary. However, family members who have a low income usually provide modest care in terms of fulfilling the health of other family members who are experiencing pain (Rahman et al., 2018).

Based on this study, the researcher concludes that the 14 respondents of the control group have low education where this causes them to lack in seeking and obtaining information about the illnesses experienced by their family members, so they are impressed to answer questions randomly. Factors from work and income also indicate that the lack of income and lack of family knowledge and self-awareness causes families to be reluctant to care for family members who experience mental disorders. The results of the analysis of family self-awareness data in the treatment group showed the influence of family psychoeducation on increasing family self-awareness in caring for family members who experience mental disorders.

Previous research that supports is research conducted by Wiyati in 2010 about the effect of family psychoeducation on the ability of families to care for clients of social isolation (Wiyati et al., 2010). The results of the study stated that family psychoeducation therapy could improve cognitive abilities because the therapy contains elements to increase family knowledge, teach care techniques, and increase support for family members themselves. Family behavior based on conscious knowledge gained from psychoeducation will have a long-term impact (Notoatmodjo, 2012).

Research conducted by Ilias, Pnnusamy and Normah in 2008 states that family psychoeducation is effective in reducing parental stress, which also impacts on family psychological wellbeing (Ilias et al., 2008). Another study conducted by Rosmaharani in 2015 on the effect of family psychoeducation on changes in anxiety levels and perceptions of family burdens caring for children with mental retardation shows the results that psychoeducation affects reducing anxiety and perceptions of family burden. Psychoeducation is also effective against changes in load reduction. Psychoeducation can facilitate families to explore feelings openly so that the results obtained are satisfying (Rosmaharani, 2015).

Psychoeducation is an act of modality delivered by professionals who integrate or synergize between psychotherapy and educational interventions. According to researchers, the knowledge provided through education will change the mindset of the family so as to increase family knowledge about the illness, management, and coping, which in turn, the family will adopt new behaviors. This is in line with the thinking of Brown in 2018 that psychoeducation will provide education or education by looking at potential threats or life development and explains individual coping strategies to adapt critically in his life (Brown, 2018). This is also supported by other opinions that psychoeducation is an action given to individuals and families to strengthen coping strategies or a special way of dealing with the difficulties of mental change, thus psychoeducation will increase the adaptation of individuals (Lukens and McFarlane, 2004).

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The results of this study, and supported by the results of previous studies, prove the hypothesis that there are significant differences in family self-awareness before and after participating in family psychoeducation interventions. Increased family self-awareness can be seen at the end of the study, which is after the implementation of the intervention in which 18 families (90%) said that the family did not feel ashamed to admit that one family member had a mental disorder so that the family felt more confident in interacting with the community. Another thing that was found was an increase in family trust in the service of health workers, as indicated by the family's willingness to take medicine regularly to the Public Health Center.

CONCLUSION

Family Self awareness of mental disorders client before family psychoeducation is not yet understood its role in motivating family members who have mental disorders, whereas self-awareness of mental family clients is increasing or in the good category after being given family psychoeducation, this is because the family already understands its role in caring for family members who have a mental disorder. Public Health Center are advised to routinely conduct mental health education to members of mental disorders clients so that family self-awareness in motivating mental disorders clients increases. The family is more trying to increase family self-awareness to support the treatment of mental disorders clients. The next researcher is expected to be able to choose other mental health education methods in order to increase the self-awareness of the mental family's client.

REFERENCES

Azwar S. (2007) Sikap Manusia Teori dan Pengukurannya. Yogyakarta: Pustaka Pelajar.

Brown NW. (2018) Psychoeducational groups: Process and practice. Routledge. https://doi.org/10.4324/9781315169590

Erfina E, Widyawati W, McKenna L, (2019) Exploring Indonesian adolescent women's healthcare needs as they transition to motherhood: A qualitative study. Women and Birth. Epub ahead of print. https://doi.org/10.1016/j.wombi.2019.02.007

Ilias K, Ponnusamy S, Normah CD. (2008) Parental stress in parents of special children: The effectiveness of psychoeducation program on parents' psychosocial well beings. Simp Sains Kesihat Kebangs Kuala. 18–19.

Issaacs A. (2005) Keperawatan Kesehatan Jiwa dan Psikiatri.

Kemenkes RI. (2013). Riset kesehatan dasar 2013. Jakarta: Badan Penelitian Dan Pengembangan Kesehatan.

Laflamme L, Engström K, Möller J, (2004) Is perceived failure in school performance a trigger of physical injury? A case-crossover study of children in Stockholm County. J Epidemiol Community Health. Epub ahead of print. https://doi.org/10.1136/jech.2003.009852

Lukens EP, McFarlane WR. (2004) Psychoeducation as Evidence-Based Practice: Considerations for Practice, Research, and Policy. Br Treat Cris Interv; 4. https://doi.org/10.1093/brief-treatment/mhh019

Martono H, Pranarka K. (2009) Buku Ajar Boedhi-Darmojo: Geriatri (Ilmu Kesehatan Usia Lanjut).

Mikhaylovsky MN, Lopatkova IV, Komarova NM, Rueva EO, Tereschuk KS, Emelyanenkova AV (2019). Cyberbulling as a new form of a threat: a physiological, psychological and medicinal aspects. Electronic Journal of General Medicine, 16(6): em161. https://doi.org/10.29333/ejgm/114268

Nihayati HE, Mukhalladah DA, Krisnana IK. (2016) Pengalaman Keluarga Merawat Klien Gangguan Jiwa Pasca Pasung. J Ners. 11: 283.

Notoatmodjo S. (2007) Promosi kesehatan dan ilmu perilaku.

Notoatmodjo, S. (2012). Buku Promosi Kesehatan dan Ilmu Perilaku Kesehatan. Jakarta. Penerbit Rineka Cipta.

Potter PA, Perry AG, Stockert P, (2016) Fundamentals of Nursing-E-Book. Elsevier health sciences.

Pradono J, Sulistyowati N. (2014) Hubungan Antara Tingkat Pendidikan, Pengetahuan tentang Kesehatan Lingkungan, Perilaku Hidup Sehat dengan Status Kesehatan. Bul SPenelitian Sist Kesehat.

Putri I V, Effendy E.(2019) Expressed emotion in a woman with bipolar disorder: A case report from deli serdang. Open Access Maced J Med Sci. 7: 2671–2674.

Rahman A, Lahdimawan A, Arifin S, (2018) The analysis of risk factors associated with nutritional status of toddler in posyandu of beringin village, alalak sub-district, barito kuala district. Indian J Public Heal Res Dev. 9: 459–464. https://doi.org/10.5958/0976-5506.2018.01387.6

Rosmaharani S. (2015) Pengaruh Psikoedukasi Keluarga Terhadap Perubahan Tingkat Kecemasan dan Persepsi Beban Keluarga dalam Merawat Anak Dengan Retardasi Mental di SDLB Negeri Kabupaten Jombang.

Saragih M, Amin MM, Husada MS. (2019) Shared psychotic disorder (Folie À deux): A rare case with dissociative trance disorder that can be induced. Open Access Maced J Med Sci. 7: 2701–2704.

Sari DK, Dewi R, Daulay W. (2019) Association between family support, coping strategies and anxiety in cancer patients undergoing chemotherapy at General Hospital in Medan, North Sumatera, Indonesia. Asian Pacific J Cancer Prev. 20: 3015–3019. https://doi.org/10.31557/APJCP.2019.20.10.3015

Stuart GW. (2014) Principles and Practice of Psychiatric Nursing-E-Book. Elsevier Health Sciences.

Suswinarto DY, Andarini S, Lestari R. (2015) Studi Fenomenologi: Pengalaman Keluarga Terhadap Pemasungan dan Lepas Pasung Pada Anggota Keluarga Yang Mengalami Gangguan Jiwa di Wilayah Kerja Puskesmas Bantur Kabupaten Malang Propinsi Jawa Timur. J Ners dan Kebidanan. Epub ahead of print. DOI: 10.26699/jnk.v2i2.

WHO. (2016) World Health Statistics 2016. Monitoring Health for the SDGs. World Health Organization. Epub ahead of print. https://doi.org/10.1017/CBO9781107415324.004

Wiyati R, Wahyuningsih D, Widayanti ED, (2010) Pengaruh psikoedukasi keluarga terhadap kemampuan keluarga dalam merawat klien isolasi sosial. Jurnal Keperawatan Soedirman, 5(2): 85-94.

Yusuf A, Putra ST, Probowati Y. (2012) Peningkatan Coping Keluarga Dalam Merawat Pasien Gangguan Jiwa Melalui Terapi Spiritual Direction. Obedience, Dan Acceptance (DOA). J Ners. 7: 2012.

Zhuang Z, Qiao W. (2018) A Study on College Students' Psychology of Revenge and Interpersonal Forgiveness and the Relationship with Health Education. Eurasia Journal of Mathematics, Science and Technology Education, 14(6): 2487-2492. https://doi.org/10.29333/ejmste/89517